DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment

Guidance for Applicants (GFA) No. TI 00-008
Part I - Programmatic Guidance

Minority Community Planning Grants for Integration of HIV/AIDS and Substance Abuse Treatment, Mental Health, Primary Care and Public Health

Short Title: HIV Services Integration Planning

Application Due Date:
July 28, 2000

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and subject to the availability of funds

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Agency

Department of Health and Human Services (DHHS), Substance Abuse and Mental Health Services Administration

Action and Purpose

Announcement of availability of 25 to 30 grants for community planning and consensus building. These grants will develop plans that describe how organizations and agencies should work together to deliver integrated substance abuse treatment, HIV/AIDS prevention and treatment, mental health, primary care and public health services. The targeted populations are racial and ethnic groups who are at the highest risk for substance abuse and HIV including:

- African Americans
- Latinos/Hispanics
- Or other racial or ethnic groups at high risk

The grants are part of a PHASE 1 Planning Program.

Summary

The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT) announces the availability of Fiscal Year 2000 funds for grants.

Approximately $3,500,000 will be available. The average award is expected to range from $100,000 to $150,000 in total costs (direct and indirect). Actual funding levels will depend on the availability of funds to SAMHSA. **Grants will be awarded for a period of 12 months.**

Background

The reported cases of AIDS are higher among African Americans and Hispanics/Latinos than other population groups in the United States (CDC, 1999). These groups also generally have much higher rates of substance abuse and sexually transmitted diseases (STDs).

To address the pressing health problem, a congressional conference report stated a need for greater integration of substance abuse and HIV/AIDS treatment and prevention services by state and local governments.

Who Can Apply

Only government units may apply because of their responsibility for the needs of their citizens. The success of the program will depend on their authority and their ability to coordinate a variety of resources and to help their citizens apply for future funding.

State government applicants must:

- Have a working relationship with a city, town, and/or county agency in order to develop plans for their targeted

population.

- Show, in a formal MOU (memorandum of understanding), an ongoing public health agreement that describes the working relationship (for example, joint activities). Include your MOU in your Appendix 1.
- Have an annual AIDS case rate of, or greater than, 10 out of 100,000 people

Local Government applicants (cities, towns, and counties) and Native American Tribal Communities must be located in one of the following**:**

- A state with an annual AIDS case rate of, or greater than, 10 out of 100,000 people.
- An MSA (metropolitan statistical area) with an annual AIDS case rate of, or greater than, 15 out of 100,000 people.

In the absence of consistent reporting of HIV data by all jurisdictions, the best indicator of the magnitude of the epidemic is AIDS case rates derived from the Center for Disease Control and Prevention (CDC) HIV/AIDS surveillance reports. See Appendix A of this document for CDC annual case rates in states and MSAs.

Application Kit

Application kits have two parts: Part I is individually tailored for each GFA. Part II contains general policies and procedures that apply to all SAMHSA applications for discretionary grants. You will need to use both Parts I and II for your application.

This document is Part I.

To get a complete application kit, including Parts I and II, you can:
Call the National Clearinghouse for Alcohol and Drug Information (NCADI) at 1-800-729-6686, or

Download from the SAMHSA site at www.SAMHSA.gov

Where to Send the Application

Send the original and 2 copies of your grant application to:
SAMHSA Programs
Center for Scientific Review
National Institutes of Health
Suite 1040
6701 Rockledge Drive MSC-7710
Bethesda, MD 20892-7710

Change the zip code to 20817 if you use express mail or courier service.

Please note:

1. Use application form PHS 5161-1.
2. Be sure to type: "TI 00-008 HIV Services Integration Planning" in Item Number 10 on the face page of the application form.

Application Dates

Send your application in by July 28, 2000.

Applications received after July 28, 2000 will only be accepted if they have a proof-of-mailing date from the carrier within 1 week of the deadline date.

Private metered postmarks are not acceptable as proof of timely mailing. Late applications will be returned without review.

Grant awards are expected to be made by September 30, 2000.

How to Get Help

For questions on *program issues*, contact:
David C. Thompson
Clinical Interventions and Organizational Models Branch
Division of Practice and Systems Development
Center for Substance Abuse Treatment
SAMHSA
Rockwall II, Suite 740
5600 Fishers Lane
Rockville, MD 20857
(301) 443-6523
E-Mail: **dthompso@samhsa.gov**

For questions on *grants management issues*, contact:
Kathleen Sample
Division of Grants Management, OPS
Substance Abuse and Mental Health Services Administration
Rockwall II, 6th floor
5600 Fishers Lane
Rockville, MD 20857
(301) 443-9667
E-Mail: **ksample@samhsa.gov**

Ideas For Developing Your Grant Application

Grants can be used for **community planning and consensus development.**
The following are some examples of activities that may be supported.

- **Providing community education**. For example, training on community planning and community change strategies.
- **Developing an executive advisory committee**. Include members from community, public, private, and corporate sectors.
- **Educating and training groups** on organizational and community change dynamics.
- **Bringing together various community groups** to seek advice and consensus.
- **Providing expert consultation and technical assistance**.
- **Funding needed for travel and other logistical costs** to consumers, family members, and others to be able to participate on committees or in programs.
- **Evaluating the community planning**

process.

- **Other activities** that focus on community planning and consensus building.

Funding Restrictions

Grant funds may **not** be used to:

- Support direct services.
- Carry out syringe exchange programs, such as the purchase and distribution of syringes and/or needles.
- Pay for pharmacologies for HIV antiretroviral therapy, STDS, TB and hepatitis B and C.

Funding Criteria

Decisions to fund a grant are based on:

1. The strengths and weaknesses of the application as shown by the
   - Peer Review Committee
   - National Advisory Council
2. Availability of funds
3. Overall program balance
   - geography including rural/urban areas
   - race/ethnicity of project population

Reporting Requirements

Applicants awarded funds will need to submit a **quarterly report**. The following activities should be reported:

1. Number of planning and consensus building events. For example, committee meetings, and meetings with stakeholders.
2. Percentage of stakeholders satisfied with these planning and consensus building events.
3. Percentage of stakeholders that report using information from these planning and consensus building events.

Evaluation results must be included in each required **interim and final report**. CSAT program staff will use this information to determine if a grantee has reached their goals.

Grantees must also agree to provide SAMHSA with **GPRA** Outcome and Evaluation Data that is described in Appendix D, Part I.

Post Award Requirements

If you are funded, you must attend two 3-day national grantee meetings. Funding for attending must be included in your budget.

The first meeting will be held within the first few months of the award. The second meeting will be held six to eight months after your project start-up.

A minimum of two persons (Program Director and a representative community stakeholder)

are expected to attend. These meetings will be held in the Washington, D.C. area.

SAMHSA Program Overview

The overall program goals, design, consensus building roles, and community planning are outlined in this section.

This program will:

1. Enable grantees to develop a community planning process. The program aims to integrate and improve the delivery of substance abuse treatment, HIV/AIDS prevention and treatment, mental health, primary care, and public health services. The program is geared toward racial and ethnic populations at high risk of HIV infection.

2. Enable grantees to develop community-wide agreement on the priorities and plans for improving the delivery of substance abuse treatment, HIV/AIDS prevention and treatment, mental health, primary care, and public health services.

3. Enable grantees to involve and help the community in planning efforts to reduce the risk of transmission of HIV/AIDS. This can be accomplished through education, prevention, treatment, and coordination of HIV/AIDS prevention and treatment services with substance abuse treatment, mental health, primary care and public health services.

Long Term Program Goals

The CSAT HIV Services Integration Planning Grant program is made up of two types of grants:

Phase I: Development of a community planning process.

Phase II: Implementation of a services integration plan.

This announcement describes only Phase I planning grant application requirements. CSAT may issue a second announcement for Phase II at a later time if Phase I plans are successfully developed and funds are available.

Phase I is designed to:

- Apply a needs assessment and a population profile to develop a services integration plan.
- Recruit community planning group members including consumers and stakeholders in community planning processes.
- Apply scientific knowledge in selecting and developing intervention strategies.

, Assess the cost/benefit of the planning process from the vantage point of the various people involved.

Role of Community Planning and Consensus Building

Community Planning:
For effective community interventions, all involved groups should be included in the community planning process. Organizations providing services to the target audience should be kept abreast of new developments. An effective planning process aims to improve the way local health departments and community-based organizations develop and implement substance abuse services and HIV treatment and prevention programs.

Consensus Building:
Representatives of the target populations, epidemiologists, behavioral and social scientists, substance abuse treatment providers, HIV/AIDS treatment and prevention providers, health department staff, and others need to work together to :

/ Assess and prioritize substance abuse and HIV treatment and prevention needs.
/ Identify substance abuse and HIV treatment and prevention interventions to meet the needs of the community as they develop a comprehensive HIV treatment and prevention plan.

Role of Applicants in Community Planning and Consensus Building
Applicants must plan and coordinate services at the local level with the SSA. When applicable, applicants should work with the CDC HIV Prevention Community Planning Groups, HIV/AIDS CDC funded projects, the Health Resources and Services Administration (HRSA) Ryan White Planning Councils, and/or the Department of Housing and Urban Development (HUD) Housing Opportunities for People with AIDS (HOPWA).

Impact of Community Planning and Consensus Building
There are several methods to help people make decisions and adapt social policy to community practice.

Positive system change is more likely to happen when people:

T Work closely with community leaders, families, consumers and other stakeholders.

T Create shared expectations and commitments.

T Build decisions on group consensus.

T Use existing resources in the community.

T Evaluate *how* changes occurred.

DETAILED INFORMATION ON WHAT TO INCLUDE IN YOUR APPLICATION

In order for your application to be **complete and eligible**, it must include the following in the order listed. Check off areas as you complete them for your application.

‘ ***1. FACE PAGE***

Use Standard Form 424. See Appendix A in Part II for instructions. In signing the face page of the application, you are agreeing that the information is accurate and complete.

Follow with: Optional Information on Application Writer

List the name, title, and organization for the main person who wrote the application on a separate sheet of paper. Listing the application writer is voluntary and will not be used to decide if an application will be accepted or funded**.**

‘ ***2. ABSTRACT***

In the first 5 lines or less of your abstract, write a summary of your project that can be used in publications, reporting to Congress, or press releases, if funded.

Your total abstract may not be longer 35 lines.

‘ ***3. TABLE OF CONTENTS***

Include page numbers for each of the major sections of your application and for each appendix.

‘ ***4. BUDGET FORM***

Standard Form 424A. See Appendix B in Part II for instructions.

‘ ***5. PROGRAM NARRATIVE* AND SUPPORT DOCUMENTATION**

The program narrative is made up of Sections A through E. More detailed information of A-E follows #10 of this checklist. The support documentation for your application is made up of sections F through I. Sections A-E may not be longer than 25 pages.

— **Section A - Project Narrative:** *Project description and need*

— **Section B - Project Narrative:** *Project impact and feasibility*

— **Section C - Project Narrative:** *Project approach*

– **Section D - Project Narrative:** *Evaluation and analysis*

— **Section E - Project Narrative:** *Project management plan, staff, equipment, facilities, and resources.*

There are no page limits for the following sections, except for Section H, the Biographical Sketches/Job Descriptions.

— **Section F- Supporting Documentation:** *Literature citations*

This section must contain complete citations, including titles and all authors, for any literature you cite in your application.

__ **Section G - Supporting Documentation:**
Budget justification, existing resources, other support

Fill out sections B, C, and E of the Standard Form 424A. Follow instructions in Appendix B, Part II.

__ **Section H - Supporting Documentation:**
Biographical sketches and job descriptions

- Include a biographical sketch for the project director and for other key positions. Each sketch should not be longer than **2 pages**. If the person has not been hired, include a letter of commitment from him with his sketch.
- Include job descriptions for key personnel. They should not be longer than **1 page**.
- ***Sample sketches and job descriptions are listed in Item 6 in the Program Narrative section of the PHS 5161-1.***

__ **Section I - Supporting Documentation:**
Confidentiality and SAMHSA Participant Protection (SPP)

The seven areas you need to address in this section are outlined after the Project Narrative description in this document.

‘ ***6. APPENDICES 1 THROUGH 4***

- Use only the appendices listed below.
- **Don't** use appendices to extend or replace any of the sections of the Program Narrative.
- **Don't** use more than **30 pages** (plus all instruments) for the appendices.

Appendix 1:
Letters of Coordination and Support including the MOU (Memorandum of Understanding) of an ongoing public health agreement. Only state applicants need to include the MOU.

Appendix 2:
Copy of Letter(s) to the Single State Agencies (SSAs). Please refer to Part II.

Appendix 3:
Data Collection Instruments and Interview Protocols

Appendix 4:
Sample Consent Forms

‘ ***7. ASSURANCES***

Non- Construction Programs. Use Standard form 424B found in PHS 5161-1.

‘ ***8. CERTIFICATIONS***

‘ ***9. DISCLOSURE OF LOBBYING ACTIVITIES***

SAMHSA's policy does not allow lobbying. Please see Part II for lobbying prohibitions.

‘ ***10. CHECKLIST***

See Appendix C in Part II for instructions.

Project Narrative– Sections A Through E Highlighted

Your application consists of addressing sections A through I. Sections A through E, the project narrative parts of your application, describe what you intend to do with your project. Below you will find detailed information on how to respond to sections A through E.

/ **Sections A though E <u>may not</u> be longer than 25 pages.**

/ **A peer review committee will assign a point value to your application based on how well you address these sections.**

/ The number of points after each main heading shows the maximum points a review committee may assign to that category. For example, a perfect score for section A will result in the award of 25 points.

/ Reviewers will also be looking for cultural competence. Points will be deducted from applications that do not adequately address the cultural aspects of the criterion. See Appendix D in Part II.

Section A:

Project Description and Justification of Need (25 points)

‘ List your project goals and objectives. State what you want to accomplish in your grant project. Describe how your goals relate to the purpose and goals of this GFA.

‘ Describe the need for community planning activities.

‘ Name the target population at whom your program is aimed. Explain why this group has been selected for your project.

‘ Describe and provide evidence on the type of problem you will address. Base your evidence on local data.

‘ Provide evidence why the target population is vulnerable to the spread of HIV/STDs, TB, and hepatitis B and C.

‘ List services currently available for the target population in your proposed target area for:

- C Substance abuse treatment
- C HIV/AIDS prevention and treatment
- C Mental health
- C Primary care
- C Public health services

Include the following:

1. A complete list of the organizations grouped by type of service. Include the organization name, address,

telephone number.
2. A complete list of services offered.
3. A list of the service or catchment areas.

‘ List the civic, community, religious, professional, consumer, and other stakeholder organizations in the targeted community that will be involved in your proposed project.

‘ Identify the specific location that will be included in your project. For example, a county jurisdiction, a city or town, or a rural area. Include the relevant census tracts.

Section B:
Project Impact/Feasibility (20 points)

‘ Describe how your proposed planning activity will help your target audience. Address why your planning goals are likely to occur if you are awarded the grant.

‘ Identify and describe how key stakeholders support this project. Stakeholders include:
- Substance abuse treatment providers
- HIV/AIDS providers
- Mental health providers
- Primary care providers
- Public health providers
- Consumers and their families.

Put letters and documents from stakeholders in Appendix 1, “Letters of Coordination and Support.”

‘ Describe problems that your plan may have in implementing the project. List methods to overcome them. These problems typically include:
- Delivery systems’ policies and human resource needs
- Alternate funding sources
- State and local legislation
- How ready systems, providers and consumers are to make changes or participate.

Section C:
Project Approach/Plans (25 points)

‘ Provide a detailed needs assessment of the targeted community in respect to HIV/AIDS, substance abuse treatment, mental health, primary care, and public health.

‘ Describe how the goals and objectives for the planning process will be achieved.

‘ Describe the major tasks you will need to do to complete the project.

‘ Describe the methods you will use to develop a plan for a more integrated services delivery system. Consider the following:

1. Develop an executive committee to oversee the development of the integration strategy. This committee should include representatives from key

city/county offices, the community, voluntary organizations, and private sector organizations.

2. Develop a community advisory or planning committee. It could include providers, religious groups, families, consumers and others.

3. Develop techniques to review the effectiveness of current strategies. Techniques should:
- Describe existing strategic or community action plans
- Identify barriers
- Make recommendations for better ways to integrate services.

‘ Describe the coordination of services at the local level and with the SSA. When applicable, list services at the CDC HIV Prevention Community Planning Groups, HIV/AIDS CDC funded projects, Health Resources and Services Administration (HRSA) Ryan White Planning Councils, and/or Housing Opportunities for People with AIDS (HOPWA), Department of Housing and Urban Development (HUD).

‘ Describe how you will address age, culture, language, sexual orientation, and gender issues. Determine your approach before, during, and after the planning process.

Section D:
Evaluation, Design, and Analysis Plan (10 points)

‘ Describe how you will evaluate your program.

/ Show progress in achieving your goals and objectives.

/ Evaluate the consensus building and decision processes used in your program plans.

/ Measure if the planning process was carried out.

/ Identify what contributed to the success or failure of the planning process.

/ Evaluate if the plans were appropriate for the specific target population.

/ Measure evidence of buy-in and participation by key community stakeholders.

‘ Name the data you will collect to describe the impact of your program once it was put in place. List what instruments you will use. List any adaptations or modification to instruments for special populations.

‘ Provide a schedule for when you plan to collect data.

‘ List how the data will be analyzed and reported. Include an experienced, objective evaluator.

‘ List techniques you will use to provide feedback from your evaluation to the

people who participated in the planning process.

- State how the project will comply with the government's needs for Government Performance and Results Act (GPRA) information. See Appendix D, Part I.

Section E:
Project Management: Implementation Plan, Organization, Staff, Equipment/Facilities, and Other Support (20 points)

- Describe the qualifications and experience of the project director, evaluator staff, and other key personnel with respect to building consensus for change.

- List the background key personnel bring to the project with respect to knowledge of the target populations's culture, language, age, sexual orientation, and gender.

- Describe your capability and experience with similar projects and populations.

- Describe the relevant experiences, capability, and commitment of proposed collaborators, consultants, and subcontractors. Letters should be attached in your Appendix 1- "Letters of Coordination and Support."

- Describe the project management plan. Give a time line for tasks and provide a staffing pattern with reasons for the amount of time for key personnel and consultants.

- Describe the relevant resources available, such as computer facilities.

NOTE:

- Although the **budget** for the proposed project is not a review criterion, the Review Group will be asked to comment on the budget after the merits of the application have been considered.

Confidentiality and SAMHSA Participant Protections (SPP)

You must address 7 areas regarding confidentiality and participant protection in your supporting documentation. However, no points will be assigned to this section.

This information will:

- Reveal if the protection of participants is adequate or if more protection is needed.
- Be considered when making funding decisions.

Some projects may expose people to risks in many different ways. In this section of your support documentation you will need to:

- Report any possible risks for people in your project.
- State how you plan to protect them from those risks.
- Discuss how each type of risk will be dealt with, or why it does not apply to the project.

The following 7 issues must be discussed:

Ø Protect Clients and Staff from Potential Risks:

- Identify and describe any foreseeable physical, medical, psychological, social, legal, or other risks or adverse effects.
- Discuss risks which are due either to participation in the project itself, or to the evaluation activities.
- Describe the procedures that will be followed to minimize or protect participants against potential health or confidentiality risks. Make sure to list potential risks in addition to any confidentiality issues.
- Give plans to provide help if there are adverse effects to participants, if needed in the project.
- Where appropriate, describe alternative treatments and procedures that might be beneficial to the subjects.
- Offer reasons if you do not decide to use other beneficial treatments.

Ù Fair Selection of Participants:

- Describe the target population(s) for the proposed project. Include age, gender, racial/ethnic background. Address other important factors such as homeless youth, foster children, children of substance abusers, pregnant women, or other special population groups.
- Explain the reasons for using special types of participants, such a pregnant women, children, institutionalized or mentally disabled persons, prisoners, or others who are likely to be vulnerable to HIV/AIDS.
- Explain the reasons for including or excluding participants.
- Explain how you will recruit and select participants. Identify who will select participants.

Ú Absence of Coercion:

- Explain if participation in the project is voluntary or required. Identify possible reasons why it is required. For example, court orders requiring people to participate in a program.
- If you plan to pay participants, state how participants will be awarded money or gifts.
- State how volunteer participants will be told that they may receive services and incentives even if they do not complete

the study.

Û Data Collection:

- Identify from whom you will collect data. For example, participants themselves, family members, teachers, others. Explain how you will collect data and list the site. For example, will you use school records, interviews, psychological assessments, observation, questionnaires, or other sources?

- Identify what type of specimens (e.g., urine, blood) will be used, if any. State if the material will be used just for evaluation and research or if other use will be made. Also, if needed, describe how the material will be monitored to ensure the safety of participants.

- Provide in Appendix No. 3, "Data Collection Instruments/Interview Protocols," copies of all available data collection instruments and interview protocols that you plan to use.

Ü Privacy and Confidentiality:

- List how you will ensure privacy and confidentiality. Include who will collect data and how it will be collected.

- Describe:
  - How you will use data collection instruments
  - Where data will be stored
  - Who will or will not have access to information
  - How the identity of participants will be kept private. For example, through the use of a coding system on data records, limiting access to records, or storing identifiers separately from data.

Note: If applicable, grantees must agree to maintain the confidentiality of alcohol and drug abuse client records according to the provisions of Title 42 of the Code of Federal Regulations, Part II.

Ý Adequate Consent Procedures:

- List what information will be given to people who participate in the project. Include the type and purpose of their participation. Include how the data will be used and how you will keep the data private.
- State:
  - If their participation is voluntary
  - Their right to leave the project at any time without problems
  - Risks from the project
  - Plans to protect clients from these risks.

- Explain how you will get consent for youth, the elderly, people with limited reading skills, and people who do not use English as their first language.

  Note: If the project poses potential physical, medical, psychological, legal, social, or other risks, you should get written informed consent.

- Indicate if you will get informed consent from participants or from their parents or legal guardians. Describe how the

consent will be documented. For example: Will you read the consent forms? Will you ask prospective participants questions to be sure they understand the forms? Will you give them copies of what they sign?

- Include sample consent forms in your Appendix 4, titled "Sample Consent Forms." If needed, give English translations.

  Note: Never imply that the participant waives or appears to waive any legal rights, may not end involvement with the project, or releases your project or its agents from liability for negligence.

- Describe if separate consents will be obtained for different stages or parts of the project. For example, will they be needed for both the treatment intervention and for the collection of data. Will individuals who do not consent to having individually identifiable data collected for evaluation purposes be allowed to participate in the project?

Þ Risk/Benefit Discussion:

- Discuss why the risks are reasonable compared to expected benefits and importance of the knowledge from the project.

APPENDIX A.
Eligible States

Eligible States with Annual AIDS Rates >10 Cases per 100,000 Populations

State	Annual AIDS Case Rates 1999
Alabama	14.7
Arizona	15.8
California	17.6
Connecticut	19.0
Delaware	23.8
District of Columbia	143.3
Florida	38.1
Georgia	21.4
Hawaii	11.7
Illinois	10.7
Louisiana	20.7
Maryland	31.8
Massachusetts	20.3
Mississippi	15.7
Nevada	14.7
New Jersey	25.4
New York	42.1
North Carolina	10.5
Pennsylvania	15.0
Rhode Island	12.1

South Carolina	25.7
Tennessee	14.2
Texas	18.8
Virginia	13.4
Puerto Rico	37.5
Virgin Islands	27.9

Source: Centers for Disease Control and Prevention. HIV/AIDS Surveillance Report, 1999: 11(no. 1).

Appendix A (Continued)
Eligible MSAs

Eligible Metropolitan Areas
with Annual AIDS Rates > 15 Cases per 100,000

City, State	Annual AIDS Case Rates 1999
Atlanta, GA	29.4
Austin, TX	23.6
Baltimore, MD	47.1
Baton Rouge, LA	33.6
Bergen-Passaic, NJ	19.9
Birmingham, AL	16.7
Boston, MA	19.1
Charleston, SC	21.4
Columbia, SC	47.2
Dallas, TX	21.0
El Paso, TX	14.8
Fort Lauderdale, FL	65.8
Greenville, SC	16.1
Harrisburg, PA	16.9
Hartford, CT	22.2
Houston, TX	34.1
Jacksonville, FL	26.8
Jersey City, NJ	44.0
Las Vegas, NV	17.3
Los Angeles, CA	22.0
Louisville, KY	17.5
Miami, FL	72.5

Memphis, TN	31.9
Nashville, TN	18.2
New Haven, CT	20.1
New Orleans, LA	33.8
New York, NY	74.9
Newark, NJ	49.3
Norfolk, VA	18.2
Oakland, CA	17.7
Orlando, FL	33.6
Philadelphia, PA	28.1
Phoenix, AZ	19.3
Richmond, VA	21.7
Rochester, NY	15.3
San Diego, CA	20.3
San Francisco, CA	53.7
San Juan, PR	48.4
Sarasota, FL	17.3
Springfield, MA	18.7
Tampa-Saint Petersburg, FL	25.5
Washington, DC	28.1
West Palm Beach, FL	45.3
Wilmington, DE	24.0

Source: Centers for Disease Control and Prevention. HIV/AIDS Surveillance Report, 1999 11(No.1).

APPENDIX B.
DEFINITIONS

Community Collaboration:

- The recruitment of community planning group members to develop goals and measurable objectives.
- Aims to determine the HIV/AIDS and substance abuse service strategies relevant to the community they serve.

Co-occurring Disorders:

- When a person has both a substance abuse disorder and a non-substance abuse DSM IV Axis I or II mental disorder.
- The mental disorder is also of a type and severity that worsens the substance abuse disorder and/or complicates treatment of the substance abuse disorder.

Key Stakeholders:

- Entities and individuals whose approval and support are needed in order for a community planning and consensus building process to be put in place and maintained.
- They include, but are not necessarily limited to, consumers of substance abuse treatment services, families of consumers, advocates for consumers and families, elected and appointed policy makers, service system managers, and service providers.
- They may include systems such as legal, educational, welfare, and social services.

State:

- Any of the 50 states of the United States, the District of Columbia, the Commonwealth of Puerto Rico, the Northern Mariana Islands, American Samoa and the Trust Territory of the Pacific Islands.

System of Care:

Must meet these 6 criteria:

- Comprehensive - it provides directly or through referral for all needed services.
- Community based - it reflects the values of the community. It includes a reasonable measure of local control.
- Coordinated/integrated - it ensures effective collaboration/integration among the providers of all needed services.
- Flexible - it provides for individualized care that meets the particular circumstances of each individual and family. Includes services that may not be part of mainstream practice.
- Family centered - it involves family advocacy organizations and individual family members in every aspect of service delivery. Includes planning, budgeting, implementation and evaluation.
- Culturally appropriate- (See Appendix D of Part II "Guidelines for Assessing Cultural Competence.")

Community:

- A geo-political entity or geographic area where the proposed community planning and consensus building process is to be carried out.
- Can be a county, a city or other municipality.
- Can be an Indian tribe or tribal organization.
- Can be a region or neighborhood of a large city.

APPENDIX C.
REFERENCES

AHEC/Community Partners. (1995). From the ground up: A workbook on coalition building and community development. Amherst, MA: Author.

Backer, T.E. (1995a). Assessing and enhancing readiness for change: Implications for technology transfer. In Backer, T.E., David, S.L. & Soucy, G. (Eds). Reviewing the behavioral science knowledge base on technology transfer. Rockville, MD: National Institute on Drug Abuse.

Backer, T.E. (1995b). Dissemination and utilization strategies for foundations; Adding value to grant making. Kansas City, MO: Ewing M. Kauffman Foundation.

Klein, S.S. (1993a). Are there better ways to identify and share the best within and among federal education programs? Evaluation and Program Planning, 16(3), 227-239.

Kochlar, C. & Erickson, M.R. (1993). Business-education partnerships for the 21st century: A practical guide for school improvement. Gaithersburg, MD: Aspen Publishers.

Mattessich, P.W. & Monsey, B. R. (1992). Collaboration: What makes it work. St. Paul, Minnesota: Amherst H. Wilder Foundation.

McLellan, Thomas A., Hagan, Teresa A., Levine, Marvin, Gould, Frank, Meyers, Kathleen, Bencivengo, Mark, & Durell, Jack (1998). Supplemental social services improve outcomes in public addiction treatment. Addiction, 1998, 93(10), 1489-1499.

Schneider, A. (1994). Building strategic alliances. New Designs for Youth Development, 11(3), 23-26.

Rogers, E.M. (1995) Diffusion of innovations. New York: Free Press. Fourth edition.

Tushnet, N. (1993). A guide to developing educational partnerships. Washington, DC: U.S. Department of Education, Office of Educational Research and Improvement.

APPENDIX D.
CSAT's GPRA STRATEGY

Overview

The Government Performance and Results Act of 1993 (Public Law 103-62) requires all federal departments and agencies to develop strategic plans that specify what they will accomplish over a three to five year period, to annually set performance targets related to their strategic plan, and to annually report the degree to which the targets set in the previous year were met.

In addition, agencies are expected to regularly conduct evaluations of their programs and to use the results of those evaluations to "explain" their success and failures based on the performance monitoring data.

While the language of the statute talks about separate Annual Performance Plans and Annual Performance Reports, ASMB/HHS has chosen to incorporate the elements of the annual reports into the annual President's Budget and supporting documents. The following provides an overview of how the Center for Substance Abuse Treatment, in conjunction with the Office of the Administrator/SAMHSA, CMHS, and CSAP, are addressing these statutory requirements.

Definitions

Performance Monitoring:
The ongoing measurement and reporting of program accomplishments, particularly progress towards preestablished goals. The monitoring can involve process, output, and outcome measures.

Evaluation:
Individual systematic studies conducted periodically or "as needed" to assess how well a program is working and why particular outcomes have (or have not) been achieved.

Program:
For GPRA reporting purposes, a set of activities that have a common purpose and for which targets can (will) be established.[1]

Activity:
A group of grants, cooperative agreements, and contracts that together are directed toward a common objective.

Project:
An individual grant, cooperative agreement, or contract.

Center (Or Mission) GPRA Outcomes

The mission of the Center for Substance Abuse Treatment is to support and improve the effectiveness and efficiency of substance abuse treatment services throughout the United States. However, it is not the only agency in the Federal government that has substance abuse treatment as part of its mission.

The Health Care Financing Administration, Department of Veterans Affairs, and the Department of Justice all provide considerable support to substance abuse treatment. It shares with these agencies responsibility for achieving the objectives and targets for Goal 3 of the Office of National Drug Control Policy's Performance Measures of Effectiveness: Reduce the Health and Social Costs Associated with Drug Use.

Objective 1 is to support and promote effective, efficient, and accessible drug treatment, ensuring the development of a system that is responsive to emerging trends in drug

abuse.

The individual target areas under this objective include reducing the treatment gap (Goal 3.1.1), demonstrating improved effectiveness for those completing treatment (Goal 3.1.2), reducing waiting time for treatment (Goal 3.1.3), implementing a national treatment outcome monitoring system (Goal 3.1.4), and disseminating treatment information (Goal 3.1.5).

Objective 4 is to support and promote the education, training, and credentialing of professionals who work with substance abusers.

CSAT will be working closely with the OAS/SAMHSA, ONDCP, and other Federal demand reduction agencies to develop annual targets and to implement a data collection/information management strategy that will provide the necessary measures to report on an annual basis on progress toward the targets presented in the ONDCP plan.

These performance measures will, at an aggregate level, provide a measure of the overall success of CSAT's activities. While it will be extremely difficult to attribute success or failure in meeting ONDCP's goals to individual programs or agencies, CSAT is committed to working with ONDCP on evaluations designed to attempt to disaggregate the effects.

With regard to the data necessary to measure progress, the National Household Survey on Drug Abuse (conducted by SAMHSA) is the principal source of data on prevalence of drug abuse and on the treatment gap.

Assessing progress on improving effectiveness for those completing treatment requires the implementation of a national treatment outcome monitoring system (Target 3.1.4). ONDCP is funding an effort to develop such a system and it is projected in Performance Measures of Effectiveness to be completed by FY 2002. Until then, CSAT will rely on more limited data, generated within its own funded grant programs, to provide an indication of the impact that our efforts are having in these particular target areas. It will not be representative of the overall national treatment system, nor of all Federal activities that could affect these outcomes.

For example, from its targeted capacity expansion program (funded at the end of FY 1998), CSAT will present baseline data on the numbers of individuals treated, percent completing treatment, percent not using illegal drugs, percent employed, and percent engaged in illegal activity (i.e., measures indicated in the ONDCP targets) in its FY 2001 report with targets for future years. As the efforts to incorporate outcome indicators into the SAPT Block Grant are completed over the next several years, these will be added to the outcomes reported from the targeted capacity expansion program.

In addition to these "end" outcomes, it is suggested that CSAT consider a routine customer service survey to provide the broadest possible range of customers (and potential customers) with a means of providing feedback on our services and input into future efforts.

We would propose an annual survey with a short, structured questionnaire that would also include an unstructured opportunity for respondents to provide additional input if they so choose.

CSATs "Programs" for GPRA Reporting Purposes

All activities in SAMHSA (and, therefore, CSAT) have been divided into four broad areas or "programmatic goals" for GPRA reporting purposes:

- **Goal 1**: Assure services availability;
- **Goal 2**: Meet unmet and emerging

needs;

- **Goal 3**: Bridge the gap between research and practice; and

- **Goal 4**: Enhance service system performance[2]

The following table provides the crosswalk between the budget/statutory authorities and the "programs":

	KD&A	TCE	SAP TBG	NDC
Goal 1			X	
Goal 2		X		
Goal 3	X			
Goal 4			X	X

KD - Knowledge Development
SAPTBG - Substance Abuse Prevention and Treatment Block Grant
KA - Knowledge Application
TCE - Targeted Capacity Expansion
NDC- National Data Collection/Data Infrastructure

For each GPRA [program] goal, a standard set of output and outcome measures across all SAMHSA activities is to be developed that will provide the basis for establishing targets and reporting performance. While some preliminary discussions have been held, at this time there are no agreed upon performance measures or methods for collecting and analyzing the data.[3] In the following sections, CSAT's performance monitoring plans for each of the programmatic areas are presented. It should be understood that they are subject to change as the OA and other Centers enter into discussion and negotiate final measures.

In addition, at the end of the document, a preliminary plan for the use of evaluation in conjunction with performance monitoring is presented for discussion purposes.

1. Assure Services Availability

Into this program goal area fall the major services activities of CSAT: the Substance Abuse Prevention and Treatment Block Grant. In FY 2000 the Block grant application was revised and approved by the Office of Management and Budget to permit the voluntary collection of data from the States. More specifically:

- Number of clients served (unduplicated)

- Increase % of adults receiving services who:
  (a) were currently employed or engaged in productive activities;
  (b) had a permanent place to live in the community;
  (c) had no/reduced involvement with the criminal justice system.

- Percent decrease in
  (a) Alcohol use;
  (b) Marijuana use;
  (c) Cocaine use;
  (d) Amphetamine use
  (e) Opiate use

In addition, in the Fall of 1999 a customer satisfaction survey was designed and approved for collection from each state on the level of satisfaction with Technical Assistance and Needs Assessment Services provided to the States. More specifically:

- Increase % of States that express satisfaction with TA provided
- Increase % of TA events that result in systems, program or practice improvements

2. Meet Unmet of Emerging Needs

Into this program goal area fall the major services activities of CSAT: Targeted Capacity Expansion Grants. Simplistically, the following questions need to be answered about these activities within a performance monitoring context:

- Were identified needs met?
- Was service availability improved?
- Are client outcomes good (e.g., better than benchmarks)?

The client outcome assessment strategy mentioned earlier will provide the data necessary for CSAT to address these questions. The strategy, developed and shared by the three Centers, involves requiring each SAMHSA project that involves services to individuals to collect a uniform set of data elements from each individual at admission to services and 6 and 12 months after admission. The outcomes (as appropriate) that will be tracked using this data are:

- Percent of adults receiving services increased who:
  a) were currently employed or engaged in productive activities
  b) had a permanent place to live in the community
  c) had reduced involvement with the criminal justice system
  d) had no past month use of illegal drugs or misuse of prescription drugs
  e) experienced reduced alcohol or illegal drug related health, behavior, or social consequences, including the misuse of prescription drugs
- Percent of children/adolescents under age 18 receiving services who:
  a) were attending school
  b) were residing in a stable living environment
  c) had no involvement in the juvenile justice system
  d) had no past month use of alcohol or illegal drugs
  e) experienced reduced substance abuse related health, behavior, or social. consequences.

These data, combined with data taken from the initial grant applications, will enable CSAT to address each of the critical success questions.

3. Bridge the Gap Between Research and Practice

This "program" or goal covers that set of activities that are knowledge development/research activities. Initially funded in FY1996, CSAT's portfolio in this area currently includes multi-site grant and cooperative agreement programs, several of which are being conducted in collaboration with one or more of the other two Centers.

These activities cover a broad range of substance abuse treatment issues including adult and adolescent treatment, treatments for marijuana and methamphetamine abuse, the impact of managed care on substance abuse treatment, and the persistence of treatment effects.

In FY1999, a general program announcement to support knowledge development activity will be added to the CSAT portfolio.

The purpose of conducting knowledge development activities within CSAT is to provide answers to policy-relevant questions or develop

cost-effective approaches to organizing or providing substance abuse treatment that can be used by the field. Simplistically then, there are two criteria of success for knowledge development activities:

- Knowledge was developed; and
- The knowledge is potentially useful to the field.

While progress toward these goals can be monitored during the conduct of the activity, only after the research data are collected, analyzed, and reported can judgments about success be made.

CSAT proposes to use a peer review process, conducted after a knowledge development activity has been completed, to generate data for GPRA reporting purposes. While the details remain to be worked out, the proposal would involve having someone (e.g., the Steering Committee in a multi-site study) prepare a document that describes the study, presents the results, and discusses their implications for substance abuse treatment.

This document would be subjected to peer review (either a committee, as is done for grant application review or "field reviewers", as is done for journal articles). The reviewers would be asked to provide ratings of the activity on several scales designed to represent the quality and outcomes of the work conducted (to be developed).[4]

In addition, input on other topics (such as what additional work in the area may be needed, substantive and "KD process" lessons learned, suggestions for further dissemination) would be sought. The data would be aggregated across all activities completed (i.e., reviewed) during any given fiscal year and reported in the annual GPRA report.

3.1 Promote the Adoption of Best Practices
This "program" involves promoting the adoption of best practices and is synonymous currently with Knowledge Application.[5] Within CSAT, these activities currently include the Product Development and Targeted Dissemination contract (to include TIPS, TAPS, CSAT by Fax, and Substance Abuse in Brief), the Addiction Technology Transfer Centers, and the National Leadership Institute.

In FY1999, the Community Action Grant program will be added and in FY2000, the Implementing Best Practices Grant program will be added.

Activities in this program have the purpose of moving "best practices," as determined by research and other knowledge development activities, into routine use in the treatment system. Again simplistically, the immediate success of these activities can be measured by the extent to which they result in the adoption of a "best practice."[6]

In order to provide appropriate GPRA measures in this area, CSAT plans to require that all activities that contribute to this goal to collect information on the numbers and types of services rendered, the receipt of the service by the clients and their satisfaction with the services, and whether the services resulted in the adoption of a best practice related to the service rendered.

4. Enhance Service System Performance
As described earlier, this programmatic goal is distinguished from "Promote the adoption of best practices" primarily by its reliance on the Block

Grant set-aside for funding and the explicit emphasis on "systems" rather than more broadly on "services."

The CSAT activities that fall into this goal are the STNAP and TOPPS. While CSAT has established performance measures for these activities individually, it is waiting for SAMHSA to take the lead in developing SAMHSA-wide measures. In addition, CSAT continues to believe that this goal should be collapsed into the broader goal of "Promoting the adoption of best practices."

Evaluations

As defined earlier, evaluation refers to periodic efforts to validate performance monitoring data; to examine, in greater depth, the reasons why particular performance measures are changing (positively or negatively); and to address specific questions posed by program managers about their programs.

These types of evaluation are explicitly described, and expected, within the GPRA framework. In fact, on an annual basis, the results of evaluations are to be presented and future evaluations described.

To date, CSAT has not developed any evaluations explicitly within the GPRA framework. The initial requirements will, of necessity, involve examinations of the reliability and validity of the performance measures developed in each of the four program areas.

At the same time, it is expected that CSAT managers will begin to ask questions about the meaning of the performance monitoring data as they begin to come in and be analyzed and reported. This will provide the opportunity to design and conduct evaluations that are tied to "real" management questions and, therefore, of greater potential usefulness to CSAT.

CSAT will be developing a GPRA support contract that permits CSAT to respond flexibly to these situations as they arise.

On a rotating basis, program evaluations will be conducted to validate the performance monitoring data and to extend our understanding of the impacts of the activities on the adoption of best practices.

Endnotes:

1. GPRA gives agencies broad discretion with respect to how its statutory programs are aggregated or desegregated for GPRA reporting purposes.

2. Goal 4 activities are, essentially, those activities that are funded with Block Grant set-aside dollars for which SAMHSA seeks a distinction in the budget process (i.e., National Data Collection/Data Infrastructure).

3. Only measures of client outcomes have been developed and agreed to by each of the Centers. However, these measures are really only appropriate for "services" programs where the provision of treatment is the principal purpose of the activity (i.e., Goals 2 and 3). The client outcome measures will be presented under Goals 2 and 3.

4. The ratings would include constructs such as adherence to GFA requirements, use of reliable and valid methods, extent of dissemination activities, extent of generalizability, as well as the principal GPRA outcome constructs.

5. Most, if not all, of the activities conducted under the rubric of technical assistance and infrastructure development are appropriately classified as activities supporting this program goal. Technical assistance activities within GPRA have not been discussed within CSAT. Further, at this time, SAMHSA has a separate program goal for infrastructure development (see

"Enhance Service System Performance," below).

6. Ultimately, the increased use of efficient and effective practices should increase the availability of services and effectiveness of the system in general. However, measures of treatment availability and effectiveness are not currently available. Within existing resources, it would not be feasible to consider developing a system of performance measurement for this purpose.